

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005016	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 06/12/2014
NAME OF PROVIDER OR SUPPLIER LUTHERAN HOSPITAL OF INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 7950 W JEFFERSON BLVD FORT WAYNE, IN 46804		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for investigation of a State complaint.</p> <p>Complaint Number: IN 00149041</p> <p>Unsubstantiated: Lack of sufficient evidence.</p> <p>Date: 6-12-14</p> <p>Facility Number: 005016</p> <p>Surveyor: Brian Montgomery, RN, BSN Public Health Nurse Surveyor</p> <p>Lutheran Hospital of Indiana is in compliance with 410 IAC 15-1.6-2, Emergency services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 06/24/14</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE